The Rhode Island Chronic Care Sustainability Initiative: A Multi-Payer Demonstration of the Patient-Centered Medical Home

Vision	Rhode Islanders enjoy excellent health and quality of life. They are active participants in an affordable, integrated healthcare system that promotes wellness and delivers high quality comprehensive primary care.
Mission	The mission of CSI is to lead the transformation of primary care in Rhode Island. CSI brings together critical RI payers, providers, purchasers, consumers and other leaders to develop, implement, evaluate, refine and spread models to deliver, pay for, and sustain high quality comprehensive primary care.
Governance	Steering Committee composed of providers, health plans, purchasers, state agencies, and community organizations
Convener	Rhode Island Office of the Health Insurance Commissioner
Project management and funding	· Dedicated Project Management · Initial support provided by the Center for Healthcare Strategies · Current funding provided by all Rhode Island health insurers and the Rhode Island Foundation
Participating practices	5 pilot sites started in October 2008 · Include a federally qualified health center, an academically affiliated internal medicine practice, two family medicine practices, and an internal medicine practice · All sites have achieved NCQA PPC-PCMH Level 3 recognition · All sites have electronic medical records 8 expansion sites added in April 2010 · Include a federally qualified health center, a hospital-based family medicine residency program, a hospital-owned family medicine practice, two internal medicine practices, 3 independent family medicine physicians, and 2 independent internal medicine physicians · All sites have achieved NCQA PPC-PCMH Level 1 or Level 3 recognition · All sites have electronic medical records
Providers	· 65 providers and 39 family medicine residents
Patients	· 46,000 covered lives, including 34,000 commercial, 7,000 Medicaid managed care, and 5,000 Medicare Advantage patients · Medicare participation beginning in Summer 2011 will bring an additional 9,500 patients into the demonstration
Payment model	· An enhanced care management fee to participating practices from all insurers for all active patients · An on-site nurse care manager funded by the health insurers at each participating practice
Key features	· One of the first medical home demonstrations in the country with virtually 100% payer participation · Standardized and consistent public contract terms, reporting requirements, and quality measures for all providers and all payors · Emphasis on improving care for diabetes, coronary artery disease, and depression and on reducing ER use, hospitalizations, and re-admissions through improved care management, transition planning, co-location of services, maintenance of disease registries, and tracking of quality measures · Alignment with Medicaid fee-for service payments and terms · Selected as one 8 states to participate in the Medicare Advanced Primary Care Practice Demonstration · New practice revenue ranges from $30,000 to $300,000 per year, depending on practice size · Medical home implementation supported through a collaborative training model provided by the state's Quality Improvement Organization and funded by the Rhode Island Foundation · Formal evaluation by the Harvard School of Public Health and funded by the Commonwealth Fund · Participation in common evaluation and best practices collaborative with leading PCMH states, led by Vermont and convened by the Milbank Fund

January 2011